

## South Carolina Department of Health and Human Services

Please return by: \_\_\_\_\_

From: \_\_\_\_\_  
**SCDHHS - Central Mail** \_\_\_\_\_  
 PO Box 100101 \_\_\_\_\_  
 Columbia, SC 29202-3101 \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 To: (name and address of employer) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of Employee: (first, middle initial, last) \_\_\_\_\_  
 Social Security No.: \_\_\_\_\_  
 Case Name: (if different from employee name) \_\_\_\_\_  
 Case Number: \_\_\_\_\_  
 Signature of Authorized Agency Official: \_\_\_\_\_

**I understand the Department of Health and Human Services considers my income in determining my family's eligibility for assistance. I hereby authorize my employer to release the following information about my wages.**

**Signature of Employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Items checked are to be completed by employer for dates** \_\_\_\_\_ **through** \_\_\_\_\_.

- ☐ Date employment began: \_\_\_\_\_. If this is a new job, date first check was received: \_\_\_\_\_.
- ☐ Employee is paid: ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly ☐ Other: \_\_\_\_\_.
- ☐ Hours expected to work per pay period after training period ends: \_\_\_\_\_.
- ☐ Wages per hour: \_\_\_\_\_. If not paid hourly, wages expected per pay period: \_\_\_\_\_.
- ☐ Is this seasonal employment? ☐ Yes ☐ No Day of week pay is usually received by employee: \_\_\_\_\_.
- ☐ Other expected earnings not included above (tips, commissions, etc.): \_\_\_\_\_.
- ☐ Number of dependents claimed for federal income tax purposes: \_\_\_\_\_. Marital status: \_\_\_\_\_.
- ☐ Is employee covered by a health insurance program? ☐ Yes ☐ No Insurance company's name: \_\_\_\_\_.
- ☐ Does employee have any type of savings plan at work (credit union, Christmas Club, etc.)? ☐ Yes ☐ No  
 If yes, give type of account and current balance: \_\_\_\_\_, Direct deposit of wages? ☐ Yes ☐ No
- ☐ Do you anticipate any changes in hourly rate or work hours? ☐ Yes ☐ No  
 If yes, please indicate change and expected date of change: \_\_\_\_\_.
- ☐ **List wage information below:** Gross pay refers to the total wages earned before any deductions and includes the employee share of social security paid by the employer for the employee.

Date Pay Period Ends	Date Pay Received	Hours Worked	Gross Pay	Tips, Bonus, Commission not included in gross	Any Benefits, Workman's Compensation, Disability, Maternity		Sick, Severance, Vacation Pay		Earned Income Credit	Eligible for UCB
					Type	Amount	Type	Amount		

- ☐ **If employee is on leave or laid off**, please indicate type of leave: \_\_\_\_\_. Date of final check: \_\_\_\_\_  
 Gross amount of final check: \_\_\_\_\_ Date employee is expected to return to work: \_\_\_\_\_
- ☐ **If employment has terminated**, please indicate reason employment ended: \_\_\_\_\_  
 Date of final check: \_\_\_\_\_ Gross amount of final check: \_\_\_\_\_

Signature and Title of Person Providing Information: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**Please provide income information beginning with the month of \_\_\_\_\_ and continuing to \_\_\_\_\_.**

[illegible]

Signature and Title of Person Providing Information:\_\_\_\_\_

Telephone: \_\_\_\_\_ Date Signed: \_\_\_\_\_

## Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Janet Bell, ADA and Civil Rights Official, by mail at: PO Box 8206, Columbia, SC 29202-8206; by phone at: 1-888-549-0820 (TTY: 1-888-842-3620); or by email at: [civilrights@scdhhs.gov](mailto:civilrights@scdhhs.gov).

If you believe that SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person or by mail or email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

## Language Services

**If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).**

**si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).**

إذا كانت لغتك الأساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجاناً. اتصل على الرقم:  
**888-549-0280 (رقم هاتف الصم والبكم 1-888-842-3620)**

**Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).**

**Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).**

**Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).**

**Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)**

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

**Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.**

**धयद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह । 1-888-549-0820 (TTY: 1-888-842- 3620) पर कॉल कर ।**

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

**Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in ko thei.**

**Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).**

နမူနာကတိကညီ ကျိအယိ, နမူနာ ကျိအတိမၤစၢၤလၢ တလၢ်ဘျၢ်လၢ်စ့ၤ နီတမံၤဘၣ်သ့န့ၣ်လီၤ. ကိး  
888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው፡ 1-888-842-3620)፡፡

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် ငဲ့အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ်ဆိုပါ။